



Notice to Applicant Regarding REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Illinois. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Blue Cross and Blue Shield of Illinois:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment: _____
- ☐ Other (please specify): _____

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

AGENT'S SIGNATURE

PRINTED NAME OF APPLICANT

PRINTED NAME OF AGENT

APPLICANT'S SIGNATURE

AGENT'S WRITING ID NUMBER

DATE

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement Insurance Plans have eligibility requirements, exclusions and limitations. For costs and complete details (including outlines of coverage), call a licensed insurance agent at the toll-free number shown.

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

HMO, HMO-POS and PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and ILBCBSIC's plans depends on contract renewal.